Veterans and Human Services Levy
Evaluation Matrix

Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 1 - Enhancing Access to Services for Veterans and Their Families					
Improve the lives of vulnerable King County Veterans and their families by helping them attain and sustain a stable, successful life	1.1 A Expand geographic range of King County Veterans' Program (KCVP) in North and East County; Enhancing Access to services for veterans, military members, and their families	Increase the number of at-risk Veterans and their families served who live outside of the City of Seattle	1. # of new services and demographics of clients served at the South King County office 2. # of clients who had not previously accessed services in Seattle 3. # of new services and demographics of clients served through mobile outreach 4. # of clients contacted through mobile outreach 5. # of new clients engaged in services who had not previously engaged in services, or who have been reconnected to services	1. Output 2. Outcome 3. Output 4. Outcome 5. Outcome	Demographics semi-annually Service stats annually Outcome results annually after establishing benchmarks
	1.1 B Consultation and resources for School staff serving military children (Pilot)	Reduce the impact of service on Children off military parents	1. # and demographics served and level of financial support received 2. # demonstrating increased financial stability of household	1. Output 2. Outcome	Demographics semi-annually Service stats and outcomes annually

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Strategy 1 - Enhancing Access to Services for Veterans and Their Families					
Improve the lives of vulnerable King County Veterans and their families by helping them attain and sustain a stable, successful life	1.1 C Outreach to special populations	Increase access to services and resources for underserved veterans populations	1. # and demographics of clients contacted by outreach agencies 2. # of persons applying for and/or receiving benefits/ services after referral by outreach agencies 3. # of clients who had previously not accessed or were reconnected with Veterans benefits/services 4. Client satisfaction with outreach services provided	1. Output 2. Outcome	Demographics semi-annually Service stats and outcomes annually
	1.1D National Guard Family Assistance Center Coordinator WDVA	Reduce the impact of service on Families of national Guard and reserves	1. # and demographics served 2. # of household contacted, assessed and referred 3. # of referrals made to support services and number successful referrals 4. # demonstrating increased stability within 6 months of initial assessment	1. Output 2. Outcome 3. Outcome 4. Outcome	Demographics semi-annually Service stats and outcomes annually
	1.2.A.1 Increase capacity of KCVP Financial assistance	Reduce the impact of immediate financial strain on household stability by providing funds to meet basic needs and overcome financial crisis	1. # and demographics served and level of financial support received 2. # demonstrating increased financial stability of household	1. Output 2. Outcome	Demographics semi-annually Service stats and outcomes annually

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Strategy 1 - Enhancing Access to Services for Veterans and Their Families					
Improve the lives of vulnerable King County Veterans and their families by helping them attain and sustain a stable, successful life	1.2 A 2 Increase capacity of KCVP for additional shelter beds Compass Center/Salvation Army	Reduce the impact of homelessness by providing emergency shelter and transitional housing to veterans through vouchers to service providers	1. # and demographics served and level of financial support received 2. # of bed nights provided through emergency shelter and transitional housing	1. Output 2. Outcome	Demographics semi-annually Service stats and outcomes annually
	1.2 A 3 Increase capacity and number of units for housing for Veterans – HCSD Housing Planner	Reduce the number of veterans who are homeless by increasing the number of permanent housing units available to serve them	1. # of housing units created and occupied by formerly homeless persons 2. # and demographics of persons occupying the new units	1. Output 2. Outcome	Annual reports
	1. 2 B Mental health assessment and referral KCVP	Identify the symptoms of PTSD,TBI, addiction and mental health services among veterans and their families, and make appropriate referrals to resources	1. # and demographics served and type of services provided 2. # and assessment of presenting level of PTSD, addiction and/or mental health issues 3. # of clients referred to and receiving, services for PTSD, addiction and/or mental health problems	1. Output 2. Outcome 3. Output	Demographics semi-annually Service stats and outcomes annually
	1. 2 B Contracted PTSD treatment for veterans & their families WDVA	Reduce the symptoms and impacts of PTSD on the lives of veterans and their families	1. # and demographics served and type of services provided 2. # and assessment of presenting level of PTSD 3. # of client demonstration reduced level of PTSD, addiction and/or mental health problems	1. Output 2. Outcome 3. Outcome	Demographics semi-annually Service stats and outcomes annually

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Strategy 1 - Enhancing Access to Services for Veterans and Their Families					
Improve the lives of vulnerable King County Veterans and their families by helping them attain and sustain a stable, successful life	1.2 C Contracted Veterans Incarcerated Program (KCCF)	Assist incarcerated veterans to overcome factors contributing to jail sentencing and promote long term health and stability upon release	1. # and demographics served and type of services provided 2. Number of reduced jail days for veterans. 3. # and % of reduced recidivism among veterans with criminal justice involvement 4. # and % increase of incarcerated veterans that are eligible for early release from incarceration.	1. Output 2. Outcome 3. Outcome 4. Outcome	Demographics semi-annually Service stats and outcomes annually
	1. 2 D.1 Employment, outreach and case mgt in S & E King County KCVP	Improve the long term financial stability of veterans and their families by providing access to livable wage jobs	1. # and demographics served and type of services provided 2. # of clients connected to services through outreach 3. # of clients completing agreed upon case plans 4. # of veterans and assisted family members who secure employment 5. # referred to alternative housing arrangements 6. # of veterans and assisted family members who enter and complete education programs leading to increased employment 7. Increase in family income demonstrated by pre and post wages of employed clients	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Demographics semi-annually Service stats and outcomes annually

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Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 1 - Enhancing Access to Services for Veterans and Their Families					
Improve the lives of vulnerable King County Veterans and their families by helping them attain and sustain a stable, successful life	1. 2 D.2 Veterans Reintegration project WDVA	Improve the long term financial stability of veterans and their families by providing access to livable wage jobs	1. # and demographics served and type of services provided 2. # of clients connected to services through outreach 3. # of clients completing agreed upon case plans 4. # of veterans and assisted family members who secure employment 5. # referred to alternative housing arrangements 6. # of veterans and assisted family members who enter and complete education programs leading to increased employment 7. Increase in family income demonstrated by pre and post wages of employed clients	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Demographics semi-annually Service stats and outcomes annually
	1.2 E Veterans Conservation Program Training KCVP	Improve the long term financial stability of veterans and their families by providing training in livable wage green jobs	1. # and demographics served and type of services provided 2. # of veterans and assisted family members who complete training 3. secure employment 4. # and types of clients who retain employment	1. Output 2. Outcome 3. Outcome 4. Outcome	Demographics semi-annually Service stats and outcomes annually
	1.3 Provide dedicated phone resource for veterans	Improve the quality and accessibility to appropriate resources by those in need through a dedicated phone system	1. # and demographics of those using the dedicated resource 2. # of persons applying for and/or receiving needed services after referral by the dedicated phone system 3. Client satisfaction with information and referral services provided	1. Output 2. Outcome 3. Outcome	Demographics semi-annually Service stats and outcomes annually

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Strategy 1 - Enhancing Access to Services for Veterans and Their Families					
Improve the lives of vulnerable King County Veterans and their families by helping them attain and sustain a stable, successful life	1.4 Provide training and information for community providers on VA services and linkages	Expand the county human service system capability to provide appropriate referral to veterans services	1. # of non-service providers demonstrating Increase knowledge of the issues facing veterans and the aftereffects of military service on veterans and their families *2.* # of primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing support providers who can identify appropriate referral for veteran services	1. Output *2.* Outcome	As education project is implemented

Goal	Strategies	Sub-goal and/or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 2 - Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment					
End homelessness for vulnerable at-risk individuals and families by providing resources that improve their ability to secure and maintain permanent housing	2.1(a-1) Identify high utilizers of institutional resources to target with outreach and engagement MHCADSD	Create a coordinated database that will identify homeless individuals that are high utilizers of sobering, courts jail and the health system. June 2008	1. List of High Utilizers is created 2. Demographic and service profile of High Utilizers is created 3. Cost of current services being provided to high utilizers in the established data base	1. Outcome 2. Output 3. Outcome	Report out at Project end 2010

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Strategy 2 - Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment					
End homelessness for vulnerable at-risk individuals and families by providing resources to that improve their ability to secure and maintain permanent housing	2.1 (a-2.a) Develop expanded outreach and engagement for high utililizers and chronically homeless in Seattlle MHCADSD – Pioneer Human Services @ Sobering Center	Link high utilizers and chronically homeless substance abusers in Seattle to engagement programs and housing placements to reduce homelessness and excessive use of expensive services. June 2008 -	1. Demographics of clients, 2. # of client linked to services 3. # of clients who moved in to permanent housing	1. Output 2. Outcome 3. Outcome	Demographics semi-annually Service stats semi-annually Pre-post evaluation at Project end
	2.1 (a-2.b) Develop expanded outreach and engagement for high utililizers – Seattle REACH (PHSKC)	Link high utilizers and chronically homeless substance abusers in Seattle to engagement programs and housing placements to reduce homelessness and excessive use of expensive services.	1. Demographics of clients, referrals and services provided by outreach project 2. # of clients engaged in services 3. # of clients linked to services 4. # moving into permanent housing	4. Output 5. Outcome 6. Outcome 7. Output 8. Output Output	Demographics semi-annually Service stats semi-annually Pre-post evaluation at Project end
	2.1(b-1) Develop expanded outreach and engagement in South King PATH	Connect or reconnect homeless persons in South King County to needed service and housing	1. Demographics of clients served by outreach project 2. # of persons moved in to transitional housing 3. # of persons moving into and retaining permanent housing 4. # of persons enrolled in treatment 5. # of persons enrolled in primary care 6. # of persons with increase in income	9. Output 10. Outcome 11. Outcome 12. Output 13. Output 14. Output	Demographics semi-annually Service stats semi-annually Retention and enrollment stats annually
	2.1(b-2) Develop expanded medical outreach and engagement in South King Health Care for the Homeless	Connect or reconnect homeless persons in South King County to needed medical services through expanded mobile medical capacity	1. Demographics of clients served by outreach project 2. # of clients receiving medical services 3. # of client visits per location 4. # of referrals by type of referral, including successful linkages with outreach workers (above) 5. # of stakeholder meetings 6. Pre-post increase in total #'s receiving services in South King County	1. Output 2. Outcome 3. Output 4. Output 5. Output 6. Outcome	Demographics semi-annually Service stats semi-annually

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Evaluation Matrix

Goal	Strategies	Sub-goal and/or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 2 - Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment					
End homelessness for vulnerable at-risk individuals and families by providing resources to that improve their ability to secure and maintain permanent housing	2.2 Permanent housing - Capital Funds for Permanent Housing	Increase the number of permanent housing units available to serve homeless individuals	1. # of housing units created and occupied by formerly homeless persons 2. # and demographics of persons occupying the new units	1. Outcome 2. Output	Annual reports
	2.3 Invest in Landlord Risk Reduction Fund	Maintain or increase the number of permanent housing rental units accessible to homeless individuals by reducing landlord economic risk and providing follow up support to tenants	1. # of new rental units created by enrolling landlords who previously would not rent to homeless persons 2. # of rental units retained by enrolling landlords who would not continue to rent to homeless persons 3. #, demographics and services provided to persons occupying the units 4. # of tenants successfully retaining rental units 5. Landlord satisfaction with program	1. Outcome 2. Outcome 3. Output **4.** Outcome **5.** Output	Demographics semi-annually Service stats annually Retention and enrollment stats annually
	2.4 (a) Invest in supportive services and operating costs for current and new permanent housing	Improve the ability of formerly homeless people to retain permanent housing by providing comprehensive on-site services and connection to community resources	1. #, demographics and services (medical, MH, CD) provided to homeless people moving into permanent housing 2. # linked to community-based primary health care services 3. # of residents with mental health and/or substance abuse conditions, who engage in services for those conditions 4. # of residents with chronic health conditions who set a self-management goal 5. # of clients who remain in stable housing for a minimum of 1 year	1. Output 2. Output 3. Output 4. Output 5. Outcome	Demographics semi-annually Service stats annually Retention stats annually
	2.4 (b) Invest in supportive services and operating costs for current and new permanent housing	Improve the ability of formerly homeless people to retain permanent housing by providing comprehensive on-site services and connection to community resources	1. #, demographics and services (medical, MH, CD) provided to homeless people moving into permanent housing 2. # of residents with improved perception of quality of life 3. # of residents with reduced use of intensive public services 4. # of clients who remain in stable housing annually	1. Output 2. Output 3. Output 4. Outcome	Demographics semi-annually Service stats annually Retention stats annually

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Evaluation Matrix

Goal	Strategies	Sub-goal and/or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 2 - Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment					
End homelessness for vulnerable at-risk individuals and families by providing resources to that improve their ability to secure and maintain permanent housing	2.5 (a) Enhance the housing and supportive service program of the KCJI for individuals with histories of long-term homelessness	Provide supportive housing options and services to homeless offenders who are mentally ill or have co-occurring disorders and reentering the community to end their continued homelessness	1. # who reduce community and state psychiatric hospital admissions and days 2. #, demographics and services provided to ex-offenders and MH court referrals who are homeless 3. # who reduce community and state psychiatric hospital admissions and days 4. # who reduce jail bookings and days incarcerated 5. # who reduce acute substance use/detoxification services 6. # who move into supportive housing 7. Levels of disability and disorders among clients served	1. Outcome 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output	Demographics semi-annually Service stats annually Retention stats annually Outcome results annually after establishing benchmarks
	2.5 (b) Enhance the housing and supportive service program of the KCJI for individuals with histories of long-term homelessness	Provide supportive housing options and services to homeless offenders who are mentally ill or have co-occurring disorders and reentering the community to end their continued homelessness	1. # and demographics of clients who are engage in services 2. who move into supportive housing 3. # who retain supportive housing#, demographics and services provided to ex-offenders and MH court referrals who are homeless 4. # who reduce community and state psychiatric hospital admissions and days 5. # who reduce criminal justice involvement	1. Outcome 2. Outcome	Demographics semi-annually Service stats annually Retention stats annually Outcome results annually after establishing benchmarks

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Evaluation Matrix

Goal	Strategies	Sub-goal and/or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 2 - Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment					
End homelessness for vulnerable at-risk individuals and families by providing resources that improve their ability to secure and maintain permanent housing	2.6 Invest in permanent housing placement supports for single parents with children with criminal justice involvement exiting transitional housing (ref SIP pg 21)	Overcome barriers to securing and maintaining permanent housing for single parents with young children who have criminal justice system histories and who are exiting transitional housing.	1. #, demographics of households and services provided 2. # who move into permanent housing 3. # who retain permanent housing 4. # who reunify with children, or re-establish relationship with children 5. # who establish linkages to health care, mental health treatment, and chemical dependency treatment as needed 6. # who successfully complete outstanding legal obligations (parole or probation requirements) 7. # who improve educational attainment (e.g., GED or high school diploma or postsecondary workforce education credential 8. # who improve parenting skills and confidence 9. # who secure or retain employment	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	Demographics semi-annually Service stats annually Retention stats annually Outcome results annually after establishing benchmarks
Prevent homelessness for vulnerable individuals and families at risk of losing housing	2.7 Invest in housing stability program	Prevent homelessness for at-risk individuals and families by providing coordinated financial assistance to avoid eviction	1. #, demographics of households served 2. # who retain permanent housing for at least 6 months	1. Output 2. Outcome	Demographics semi-annually Service stats annually
	2.8 Link education & employment to supportive housing	Improve the housing stability of at-risk and formerly homeless individuals by overcoming health and related barriers to securing and retaining employment	1. #, demographics and services provided 2. Increase in work income 3. Increase in housing stability 4. Job placement or activity that represents an incremental improvement in employment status 5. Job retention 6. # enrolled in education programs 7. # completing education programs 8. Job readiness	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Output 6. Outcome 7. Outcome	Demographics semi-annually Service stats annually

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Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 3 - Increasing Access to Behavioral Health Services					
Increase the physical health, mental health status, and emotional stability of vulnerable individuals and family members in King County	3.1a& b Increase Access to Behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinics	Expand the availability of behavioral health service through the integration of mental health and chemical dependency with primary care at existing community clinics and public health centers	For high risk individuals, regardless of client military status, served with Human Services Levy funds: 1. # (%) Clients screened for depression, mental health, and substance abuse issues during primary care visits 2. # and demographics of clients receiving treatment through integrated behavioral health programs 3. # of sites offering expanded capacity and measured increase in resources	1. Outcome 2. Outcome 3. Outcome	Demographics Semi-annually Annual performance report
			For military personnel and eligible family members served with Veteran's Levy funds: 1. # (%) Veterans and family members screened for depression, mental health, and substance abuse issues during primary care visits 2. # (%) Veterans/military personnel screened for PTSD during primary care visits 3. # and demographics of veterans receiving treatment through integrated behavioral health programs 4. # and demographics of clients reached through outreach and engagement strategies 5. # of sites offering expanded capacity and measured increase in resources for vets	1. Outcome 2. Outcome 3. Outcome 4. Outcome 5. Outcome	Demographics Semi-annually Annual performance report

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Strategy 3 - Increasing Access to Behavioral Health Services					
Increase the physical health, mental health status, and emotional stability of vulnerable individuals and family members in King County	3.1b Increase Access to Behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinics	Improve physical and mental health status and functioning of vulnerable individuals	For high risk individuals, regardless of client military status, served with Human Services Levy funds: 1. # (%) of clients who screen positive for depression, mental health, and/or substance abuse issues 2. # (%) of clients who screen positive who receive mental health treatment and follow up care 3. # (%) of individuals receiving mental health treatment whose periodic screening results improve over time 4. Clinical outcomes in key medical diagnoses identified in client population: • Blood pressure • Blood glucose levels (for clients with diabetes) • Other major diagnoses of target population	1. Output 2. Output 3. Outcome 4. Outcome	Demographics Semi-annually Annual performance report Semi-annually on outputs in 2009 Compilation annually and project end
			For military personnel and eligible family members served with Veteran's Levy funds: 1. # (%) of veterans/military personnel who screen positive for PTSD or trauma depression, other depression or mental health concerns, or substance abuse issues 2. #(%) veteran/military family members who screen positive for depression, mental health, or substance abuse issues 3. # (%) of veterans and family members receiving mental health treatment whose periodic screening results improve over time 4. Clinical outcomes in key medical diagnoses identified in client populations: • Blood pressure • Blood glucose levels (for clients with diabetes) • Other major diagnoses of target populations	1. Output 2. Output 3. Outcome 4. Outcome	Compilation annually and project end

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Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 3 - Increasing Access to Behavioral Health Services					
	3.1 a Increase Access to Behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinics	Expand access to services for clients in underserved county areas	1. Demonstrated increase in services in underserved areas **2.** Geographic distribution of services **3.** Comparison of demographic profiles of clients served by geographic area	1. Outcome 2. Outcome 3. Process	Annual Project end
Increase the physical health, mental health status and emotional stability of vulnerable individuals and family members in King County	3.2 Invest in training in trauma sensitive services and PTSD treatment	Expand access for trauma victims and veterans to appropriate and best practice mental health treatment and support services	1. # of treatment and support service providers who are educated about trauma and the delivery of appropriate services to survivors of trauma 2. # of new trauma services developed in response to the increased provider awareness	1. Outcome 2. Outcome	Annually
	3.3 Train behavioral health providers to use evidence-based practices for PTSD - with 3.2	Expand the county human service system capability to provide appropriate and effective treatment and support services to persons affected by PTSD	1. # of non-service providers demonstrating Increase knowledge of the issues facing those who have served in the military and the family that deals with the aftereffects of that service. 2. # of primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing support providers who can identify and address trauma and PTSD in both the veteran and non-veteran populations.	1. Outcome 2. Outcome	As education project is implemented

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Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of Data Collection
Strategy 3 - Increasing Access to Behavioral Health Services					
	3.4 Invest in services to treat depression in chronically ill and disabled elderly vets, spouses, and other elderly (PEARLS)	Improve the mental health status and independent housing stability of vulnerable elderly veterans, their partners, and other elderly persons.	1. # and demographics of clients served 2. Participants pre and post scores on a depression scale will show reduction in post scores 3. Housing situation will be maintained for a minimum of three months after enrolling in the program. 4. Participants will report improved ability to effect positive changes in life. 5. Participants will represent a range of diversity, with higher percentages of persons of color than are present in the community.	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Process	Annual report

Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of data collection
Strategy 4 – Strengthening Young Families at Risk					
Enable at-risk families and their children to thrive by promoting family stability and effective child development	4.1a Expand Nurse Family Partnership and add linkages to employment opportunities	Increase the health status of first time mothers and their children by providing access to health care coverage	1. #, demographics of households and services provided 2. # and % of children and pregnant women contacted that access healthcare, including prenatal and well child care, and linked with a medical provider. 3. # of households eligible for, and securing Medicaid	1. Output 2. Outcome 3. Output	Quarterly and annually per Nurse Family Partnership project protocols Annual performance
	4.1 Expand Nurse Family Partnership and add linkages to employment opportunities	Increase positive birth outcomes for first time, low-income young women by providing services Nurse Family Partnership services.	1. # and % of births to young women participating in Nurse Family Partnership that are term deliveries (> 37 weeks gestation) and greater than 2500 grams (5.5 lbs) Outcome	1. Outcome	Quarterly and annually per Nurse Family Partnership project protocols

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Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of data collection
Strategy 4 – Strengthening Young Families at Risk					
Enable at-risk families and their children to thrive by promoting family stability and effective child development	4.1 Expand Nurse Family Partnership and add linkages to employment opportunities	Reduce child abuse and neglect among first time, low-income young mothers in King County.	1. % and #'s of families participating in Nurse Family Partnership not involved in incidences of reportable child abuse and neglect in the home for a period of 2 years from enrollment in program. 2. # and % of parents participating in the program who identify parental stress and have interventions offered.	1. Outcome 2. Outcome	Quarterly and annually per Nurse Family Partnership project protocols
	4.1 Expand Nurse Family Partnership and add linkages to employment opportunities	Improve long term family economic stability for first time low-income young mothers in King County.	1. # and % of parents graduating from the program that delay the birth of their second child for a minimum of two years after the birth of their first child. 2. # and % of parents in education programs 3. # and % of parents completing education programs 4. # and % of parents securing improved employment	1. Outcome 2. Outcome 3. Outcome	Quarterly and annually per Nurse Family Partnership project protocols
	4.2 Piloting New Services for Maternal Depression in Community Health Centers, Public Health Centers, and Other Safety Net Clinics	Increase the long term mental health status of mothers, and healthy social and emotional development of their children, by early screening and intervention in maternal depression.	1. # (%) Maternity support clients screened periodically. 2. #, demographics of pregnant and newly parenting mothers screened for depression 3. # (%) of clients presenting depression, mental health, and substance abuse issues after screening 4. # (%) and demographics of clients attending peer support groups or receiving other early intervention strategies during pregnancy or early in parenting years (0-3 years) 5. # (%) Clients receiving treatment and follow-up through integrated behavioral health programs 6. Average length of stay in behavioral health treatment and care coordination	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Output 7. Outcome	Demographics semi-annually Service stats annually Outcome results annually after establishing benchmarks

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Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of data collection
Strategy 4 – Strengthening Young Families at Risk					
			7. Demonstration of long term improved emotional and social health of children of mothers receiving depression intervention		
Enable at-risk families and their children to thrive by promoting family stability and effective child development	4.3 (a) Strengthening Families at Risk – Prevention and Early Intervention Programs (Friends of Youth – Healthy Start)	Promote healthy early childhood development through home visits that improve responsive, nurturing caregiver-child relationships and access to medical services.	1. # and demographics of clients receiving home visits 2. # of parents who are assessed for parental stress 3. # of parents (with parental stress) who receive parenting education 4. # of children and pregnant women linked with a medical provider 5. # and % of parents graduating from the program that delay the birth of their second child for a minimum of two years after the birth of their first child	1. Output 2. Output 3. Output 4. Outcome 5. Outcome	Demographics semi-annually Service stats annually Outcome results annually after establishing benchmarks
	4.3 (b) Strengthening Families at Risk – Prevention and Early Intervention Programs (Cultural Navigator)	Promote healthy early childhood development through improved language and culturally-based access to services	1. # of client contacts specific to improving parenting skills and early childhood development 2. # of agencies receiving technical assistance 3. Increase access to services embedded in the immigrant/refugee community 4. Number of clients served with expanded Levy-supported programs (pre/post analysis)	1. Output 2. Output 3. Outcome 4. Outcome	Service stats annually
	4.3 (c & d) Strengthening Families at Risk – Prevention and Early Intervention Programs (Promoting First Relationships) (Family Friend and Neighbor Network and Play & Learn Project)	Promote healthy early childhood development through training of caregivers and staff that work with high risk children under the age of five and their families to create high quality environments in which children and families learn and grow.	1. # of caregivers and staff trained 2. Number of caregivers and parents demonstrating increased knowledge of caregiver roles and child behavior, which promotes healthy and nurturing caregiver-child relationships 3. Number of Play & Learn Network members who attend quarterly meetings 4. Number of new Play & Learn facilitators trained 5. Number of community presentations on the Family, Friend and Neighbor Program and the Play & Learn project	1. Output 2. Outcome 3. Output 4. Output 5. Output	Demographics semi-annually Service stats annually Short term outcome results annually

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Strategy 4 – Strengthening Young Families at Risk					
Enable at-risk families and their children to thrive by promoting family stability and effective child development	4.4 Provide service enhancements for single parents exiting the criminal justice system, living in transitional housing	Promote the successful community reintegration and long term stability of single parents with young children leaving the criminal justice system to transitional housing by overcoming risk factors contributing to justice system involvement Where possible reunite these parents with their children in order to promote long term health of child.	1. #, demographics of households and services provided 2. # who move into permanent housing 3. # who retain permanent housing 4. # who reunify with children, re-establish relationship with children, or who have legal arrangement allowing reunification 5. # who establish linkages to health care, mental health treatment, and chemical dependency treatment as needed 6. # who successfully complete outstanding legal obligations (parole or probation requirements) 7. # who improve parenting skills and confidence	1. Output 2. Outcome 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Demographics semi-annually Service stats annually
	4.5 Invest in education and employment programs for single parents exiting the criminal justice system	Promote the long term stability of single parents with young children leaving the criminal justice system by providing increased employment skills and linking them with job opportunities	1. # who improve educational attainment (e.g., GED or high school diploma or postsecondary workforce education credential 2. # who attain employment 3. Retention of stable employment	1. Outcome 2. Outcome 3. Outcome	Demographics semi-annually Service stats annually
	4.6 Provide treatment for parents involved with the King County Family Treatment Court (FTC) for Child Dependency Cases.	Promote the health, safety and welfare of children in the dependency system by actively intervening to address the drug, alcohol and other ancillary service needs of families.	1. # and demographics of the adult clients served 2. # of intakes completed (per adult client) 3. # set for Acceptance Staffing (per adult client) 4. # enrolled with a treatment plan 5. # of Incomplete Plans, Voluntary Termination 6. # of Incomplete Plans, Involuntary Termination 7. # of Completed Plans, non-graduate 8. # of Completed Plans, program graduates	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Outcome 8. Outcome	Demographics semi-annually Service stats annually Program Evaluation report 2010

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Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of data collection
Strategy 5 – Resource Management and Evaluation					
Use the levy financial and technical resources to promote effective, accountable, and coordinated regional management of housing, health and human service resources	5.1 Evaluation of process and outcomes sought by the levy activities	Implement evaluation structure of levy funding activities that assures accountability, demonstrates service system impacts, and informs future efforts to improve and expand resources.	1. Creation of Evaluation Framework Plan 2. Creation and review of Levy Evaluation Work plan 3. Annual reports prepared on process and services 4. Interim report on levy implementation 5. Summary report and closeout of Levy 6. Interim and final reports on special evaluation projects – content defined in MOA/contracts	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome	Demographics semi-annually Service stats annually Evaluation report per workplan
	5.2 Cross system planning for youth	Plan for, and invest in, start up activities for a system of care to support youth aging out of the foster care system.	1. Creation of the plan and presentation to CEH 2. Changes based upon the implementation of the plan.	1. Outcome 2. Outcome	N/A
	5.3 Profile of offenders with mental health issues and co-occurring disorders	Create a comprehensive portrait of offenders with co-occurring disorders in order to assist in the planning of a coordinated, integrated, regional response to their needs.	1. Study created and disseminated 2. Description of implementation of strategies inferred from the profile?	1. Outcome 2. Outcome	Final report
	5.4 Planning, training, service design efforts	Respond to opportunities to plan for, train or design new Levy and human service system strategies.	1. Monitor availability and use of funds 2. Levy plan developed	1. Output 2. Outcome	N/A

Veterans and Human Services Levy
Evaluation Matrix

Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of data collection
Strategy 5 – Resource Management and Evaluation					
Implement a Homeless Management Information system in all agencies serving homeless persons in King County to improve the coordination of services and comprehensiveness of data.	5.5 Safe Harbors Homeless Management Information System	Increase participation of regional services agencies in the HMIS by providing agency level technical support to improve data quality, business processes and configure custom applications	1. Agency satisfaction with level of support for data entry in current HMIS 2. Agency satisfaction with support for transition to new HMIS system 3. Timeliness of technical support to agency 4. Improvements realized through technical assistance 5. Improved business process to meet quality standards for participation in the HMIS	1. Output 2. Output 3. Output 4. Outcome 5. Outcome	Demographics semi-annually Service stats annually
Use the levy financial and technical resources to promote effective, accountable, and coordinated regional management of housing, health and human service resources	5.6 Information Systems DCHS-KCVP	Implement a data collection, coordination system to improve Levy evaluation activities	1. Focuses on improved Veterans Information system and linkages to human services MIS		Annual progress report
	5.7 Consultation and training in HIPAA	Improve the coordination of services and sharing of client level information within the boundaries of meeting Federal and State confidentiality requirements	1. Security and confidentiality protocols (related to the high utilizer database) reviewed and compiled 2. # of professionals participating in high utilizer database 3. Professional training developed 4. # of professionals completing training for high utilizer database	1. Output 2. Output 3. Output 4. Outcome	Demographics semi-annually Service stats annually
	5.8. A - Common Data set Partnership for Health Improvement through Sharing Information (PHISI)	Promote increased cross system coordination and service integration by developing standardized tools and data elements used in levy funded projects serving adults, youth and families	1. Assessment of current status and data requirements 2. Strategy paper and business plan on opportunities for regional coordinated health Information exchange 3. Data analysis and information sharing among safety net service providers,	1. Output 2. Output 3. Outcome	Annual progress report

Veterans and Human Services Levy
Evaluation Matrix

Goal	Strategies	Sub-goal or Objective	Performance Measure	Type of Success Measure	Frequency of data collection
Strategy 5 – Resource Management and Evaluation					
Use the levy financial and technical resources to promote effective, accountable, and coordinated regional management of housing, health and human service resources	5.8. B Vulnerability Assessment Tool	Promote increased cross system coordination and service integration by developing standardized tools and data elements used in levy funded projects serving adults, youth and families	1. Development and piloting of vulnerability assessment tool 2. # of agencies trained in use and incorporation into residential placement and referrals 3. # of clients assessed using tool and service/housing outcomes based upon assessment scores	1. Output 2. Outcome 3. Outcome	Contract
	5.9 Facilitation of ongoing partnerships	Promote effective collaboration and partnerships among and between funders, service providers and diverse community groups	1. New collaborations or discrete projects resulting from efforts. 2. Collaboration strategy	1. Outcome 2. Output	